

# Sierra Therapeutic Equestrian Program, Inc.

33 Bellevue Road • Washoe Valley • Nevada • 89705



## Volunteer/Staff Information Form and Health History

### General information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Legal Guardian/Caregiver Name/Address/Phone Number: \_\_\_\_\_

\_\_\_\_\_

How did you learn about the program? \_\_\_\_\_

Recent medical tests: Last Tetanus Shot: \_\_\_\_\_

### Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

### Check which areas you are interested in:

#### Program

- Horse Handling
- Sidewalking with a Student
- Stable Management
- Facility Repairs

#### Special Events

- Horse Show
- Fundraising
- Special Olympics
- Trail Rides

#### Administration

- Public Relations
- Grant Writing
- Newsletter
- Volunteer Recruitment

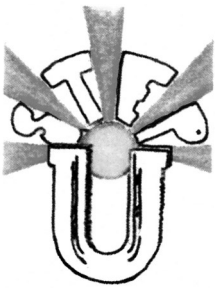
- Photography/Video
- Budget & Finance
- Future Planning

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(volunteer/staff/caregiver; signed in presence of STEP staff)*

\_\_\_\_\_



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## Volunteer/Staff Information Form and Health History - Page 2

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Photo Release

- I  DO  
 DO NOT

Email: \_\_\_\_\_

consent to and authorize the use and reproduction by Sierra Therapeutic Equestrian Program, Inc.  
of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions  
or for any other use for the benefit of the center

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Background Information

Have you ever been charged with or convicted of a crime? Y N; please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ (volunteer/staff), authorize Sierra Therapeutic Equestrian Program to receive  
information from any law enforcement agency including police departments and sheriff's departments, of this state or any other state  
or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of  
state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT  
authorize STEP/PATH, its directors, officers, employees or other volunteers to disseminate this information in any way to any other  
individual, group, agency, organization or corporation.

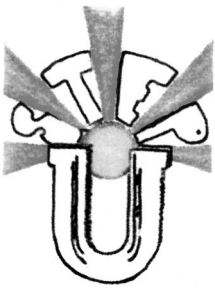
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(volunteer/staff)*

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER \_\_\_\_\_ STATE \_\_\_\_\_

### Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH center is confidential and will not be  
shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(volunteer/staff)*



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## Authorization for Emergency Medical Treatment Form

Participant     Staff     Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Sierra Therapeutic Equestrian Program to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in the presence of STEP staff*

### Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency

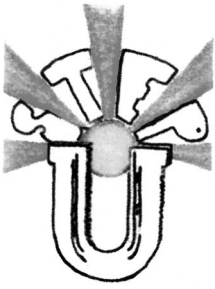
- Parent or legal guardian will remain on site at all times during equine assisted activities
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in the presence of STEP staff*



# Sierra Therapeutic Equestrian Program, Inc.

## VOLUNTEER AVAILABILITY

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  
Okay to text message you?  Yes  No

Work Phone: \_\_\_\_\_  
Okay to call you at work?  Yes  No

Email: \_\_\_\_\_

Available Days of the Week: (circle all that apply)

MON TUES WED THU FRI SAT SUN

Would like to volunteer multiple days of the week?  Yes  No

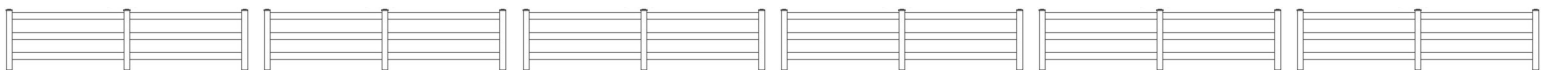
Other important information we need to be aware of when scheduling volunteer time:

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(775) 530-7073 | [stepinc@pyramid.net](mailto:stepinc@pyramid.net)

*A Non-Profit Organization*